General

Guideline Title

Recommendations on screening for breast cancer in average-risk women aged 40–74 years.

Bibliographic Source(s)

Canadian Task Force on Preventive Health Care, Tonelli M, Gorber SC, Joffres M, Dickinson J, Singh H, Lewin G, Birtwhistle R. Recommendations on screening for breast cancer in average-risk women aged 40-74 years. CMAJ. 2011 Nov 22;183(17):1991-2001. [47 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Canadian Task Force on Preventive Health Care. Canadian Task Force on the Periodic Health Examination. Canadian Guide to Clinical Preventive Health Care. Ottawa (Canada): Health Canada; 1994. Screening for breast cancer. p. 788-95. [31 references]

A complete list of planned reviews, updates and revisions is available under the What's New section at the Canadian Task Force on Preventive Health Care Web site .

Recommendations

Major Recommendations

The grades of recommendations (strong or weak) and grades of evidence (high, moderate, low, or very low) are defined at the end of the "Major Recommendations" field.

Mammography

Women Aged 40–49 Years

For women 40–49 years of age, the Task Force recommends not routinely screening for breast cancer with mammography. (Weak recommendation; moderate-quality evidence)

Women Aged 50–69 Years

For women aged 50–69 years, the Task Force recommends routinely screening for breast cancer with mammography every two to three years. (Weak recommendation; moderate-quality evidence)

Women Aged 70–74 Years

For women aged 70–74 years, the Task Force recommends routinely screening for breast cancer with mammography every two to three years. (Weak recommendation; low-quality evidence)

Magnetic Resonance Imaging (MRI)

The Task Force recommends not routinely screening for breast cancer using MRI scans. (Weak recommendation; no evidence)

Breast Examinations

The Task Force recommends not routinely performing clinical breast examinations alone or in conjunction with mammography to screen for breast cancer. (Weak recommendation; low-quality evidence)

The Task Force recommends not advising women to routinely practice breast self-examination. (Weak recommendation; moderate-quality evidence)

Definitions:

Grades of Recommendations

- Strong recommendations are those for which the task force is confident that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation for an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation against an intervention).
- Weak recommendations are those for which the desirable effects probably outweigh the undesirable effects (weak recommendation for an intervention) or undesirable effects probably outweigh the desirable effects (weak recommendation against an intervention) but appreciable uncertainty exists.

Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group Grades of Evidence

- High quality: Further research is very unlikely to change the Task Force's confidence in the estimate of effect.
- Moderate quality: Further research is likely to have an important impact on Task Force's confidence in the estimate of effect and may change the estimate.
- Low quality: Further research is very likely to have an important impact on Task Force's confidence in the estimate of effect and is likely to change the estimate.
- Very low quality: Any estimate of effect is very uncertain.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Breast cancer

Guideline Category

Screening

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Oncology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Physician Assistants

Physicians

Students

Guideline Objective(s)

To present recommendations for the use of mammography, magnetic resonance imaging (MRI), breast self-examination and clinical breast examination to screen for breast cancer among women at average risk of disease aged 40-74 years

Target Population

Women at average risk of breast cancer (defined as those with no previous breast cancer, no history of breast cancer in a first-degree relative, no known mutations in the *BRCA1/BRCA2* genes, or no previous exposure of the chest wall to radiation) aged 40-74 years

Interventions and Practices Considered

1. Mammography
2. Magnetic resonance imaging (MRI)
3. Clinical breast examinations
4. Breast self-examination (BSE)

Major Outcomes Considered

- Relative risk of death
- Survival
- Mortality
- Adverse outcomes following screening mammography (false-positive result on mammogram; unnecessary biopsy; unnecessary lumpectomy or mastectomy; fear; anxiety; distress)

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by McMaster University and the Canadian Task Force on Preventive Health Care (see the "Availability of Companion Documents" field).

The United States Preventive Services Task Force's (USPSTF's) review searched The Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews (through the fourth quarter of 2008), Medline (January 2001 to December 1, 2008), reference lists, and Web of Science for published studies, and the Breast Cancer Surveillance Consortium for screening mammography data. There were separate searches for screening, digital mammography, MRI, DCIS, adverse effects, and costs. For this update, the same search terms and databases were used, and all searches were updated to October 2011. One search strategy was altered: the limits on study methods were removed in Medline, allowing randomized controlled trials, meta-analyses, and systematic reviews to be left in the search. Reference lists of key articles were reviewed.

The EMBASE database was not searched, as it was not searched in the original review. An additional search was conducted to discover patient preferences and values; the Cumulative Index to Nursing and Allied Health Literature and Medline were searched from 2000 to October 2010. Also, a search was done for particular subgroups including rural and remote populations, Aboriginal populations, and ethnic subgroups. Medline was searched for reviews (in English) back to 1950. Medline was searched for screening frequency. A specific search of the grey literature was also done in order to find relevant Canadian statistics, using the search terms "breast cancer screening AND harms"; "mammography AND harms"; "mammography AND costs"; and "breast cancer screening AND costs". The detailed strategies for all searches are found in Appendices 1 through 5 of the systematic evidence review (see the "Availability of Companion Documents" field).

Eligible studies included women aged 40 and older, without pre-existing breast cancer and not considered to be at high risk for breast cancer on the basis of family history of breast or ovarian cancer or other personal risk factors, such as abnormal breast pathology or deleterious genetic mutations.

Study designs for effectiveness of screening (mammography, clinical breast exam, or breast self exam) included randomized controlled trials or meta-analyses with breast cancer mortality or all cause mortality as outcomes. For harms, studies of various designs and multiple data sources were included. Harms included radiation exposure, pain during procedures, patient anxiety and other psychological responses, consequences of false-positive and false-negative test results, and overdiagnosis.

Studies of cost-effectiveness of screening were included if they were relevant to the key questions. As was done for the USPSTF report, the Task Force excluded studies of costs of improving screening rates, dual review of screening mammography, or studies in populations at high-risk for breast cancer. Studies of patient preferences and values could be any study design, including qualitative studies. Studies of particular subgroups were systematic reviews. All included studies were in either English or French. Grey literature was included if it included recent relevant national Canadian data.

Addendum

The literature search for systematic reviews on the effectiveness of screening for breast cancer was completed in October 2010 but was updated to October 2011 prior to publication. Prior to the review being posted, the Task Force became aware of new follow-up data published on the Swedish Two-County Trial (East County: Östergötland; West County: Kopparberg/Dalarna). See the Appendix 1 of the original guideline document for more information.

Number of Source Documents

Seventeen new publications were identified and included: one systematic review of the effect of mammography on mortality; two systematic reviews and nine primary studies of harms; and five papers on costs. The search for information on patient preferences and values found three systematic reviews and 23 primary studies.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Grading of Recommendation Assessment, Development and Evaluation (GRADE) Working Group Grades of Evidence

- High quality: Further research is very unlikely to change the Task Force's confidence in the estimate of effect.
- Moderate quality: Further research is likely to have an important impact on the Task Force's confidence in the estimate of effect and may change the estimate.
- Low quality: Further research is very likely to have an important impact on the Task Force's confidence in the estimate of effect and is likely to change the estimate.
- Very low quality: The Task Force is very uncertain about the estimate.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by McMaster University and the Canadian Task Force on Preventive Health Care (see the "Availability of Companion Documents" field).

Quality Assessment, Data Abstraction, and Analysis

Quality assessment and data abstraction were done by two people. All disagreements were resolved through discussions rather than relying on a particular level of kappa score to indicate when discussions were no longer necessary. Data were abstracted by two people using a standard format. The exception to this process was studies related to the contextual questions of costs, patient preferences, subpopulations, and grey literature, for which abstraction was done by one person.

The strength of the evidence was determined based on the Grading of Recommendation Assessment, Development and Evaluation (GRADE) system of rating quality of evidence using GRADEPro software. This system of grading evidence has been widely used and has been endorsed by more than 40 major organizations including the World Health Organization, Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. The GRADE system classifies quality of evidence in one of four levels: high, moderate, low, and very low (see the "Rating Scheme for the Strength of Evidence" field). The final grade is based on risk of bias due to limitations in design, inconsistency of findings, indirectness, imprecision, and publication bias.

The Breast Cancer Screening Working Group rated each of the outcomes and potential harms of screening using the GRADE process, which suggests a 9-point scale (1 through 9) to judge their importance. The upper end of the scale, rankings 7 through 9, identifies outcomes of critical importance for decision making. Rankings 4 through 6 represent outcomes that are important but not critical, while rankings 1 through 3 are items that are deemed to be of limited importance to decision making or to patients. This process identified breast cancer mortality and all cause mortality as the most important primary outcomes. The secondary outcomes of harms associated with screening were ranked as in Table 1 in the original guideline document.

The GRADE process was also used to assess risk of bias for individual studies, which was then used with the summary of findings to assess the overall quality of the evidence. In addition to those required data, for each study the Task Force abstracted data about the patient population, the study design, analysis, and results. Reviews were quality assessed using the assessment of multiple systematic reviews (AMSTAR) tool.

Information to determine the quality of evidence was abstracted in duplicate from the primary methodology paper from each study. Those abstracting the data were blind to each other's ratings. In cases of disagreement, final decisions were determined by consensus after consultation with a third reviewer. Separate tables were constructed and GRADE assessments were made by study design. When the method of randomization either was deemed inadequate (e.g., randomization by date of birth) or was not clear from the primary methodology publication, a separate table was constructed for randomized controlled trials (RCTs) and quasi-randomized trials. If the summary effect size from these subgroups of trials was similar and heterogeneity did not exist, the recommendations were based on all trials (i.e., randomized and quasi-randomized); otherwise, recommendations were based on the RCT results alone. In the first circumstance, it was reasoned that, although there was potential for bias due to inadequate randomization, evidence of this bias did not exist and therefore the overall estimate was the best estimate on which to base

recommendations.

Traditional meta-analyses were undertaken using a random effects model proposed by DerSimonian and Laird. The random effects model assumes that the studies are a sample of all potential studies and incorporates an additional between-study component into the estimate of variability.

The Task Force used a test based on the deviations of the individual study estimates from the summary estimate of effect (the heterogeneity Chi^2) as their primary method to test for heterogeneity. To supplement this test the Task Force calculated a statistic to quantify heterogeneity, the I^2, which describes the proportion of the variance in the point estimate due to heterogeneity rather than sampling error. Although there are no strict rules for interpreting I^2, a rough guide is that an I^2 greater than 50% may represent substantial heterogeneity.

Publication bias was assessed using funnel plots, which graph the estimated effects against sample size. Funnel plot asymmetry indicates the likely presence of publication bias. However, there were at most nine trials included in any funnel plot, and the Cochrane Handbook suggests no fewer than ten trials, so these funnel plots are not included in this report, and the Task Force cannot be certain that publication bias is absent.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by McMaster University and the Canadian Task Force on Preventive Health Care (see the "Availability of Companion Documents" field).

Task Force Methods

For every topic selected by the Task Force, a topic working group is formed. This working group consists of two to five Task Force members who volunteer to join the working group (one of whom is selected as chair), a scientific research manager from the Public Health Agency of Canada and members from the Evidence Review and Synthesis Centre, as well as from partner organizations, if any such organizations are involved for the particular topic. The topic working group develops the analytic framework and key questions, which define the scope and focus of the review and influence the associated workload. The Task Force as a whole and partner organizations (if applicable) review and approve these documents. The chair or co-chair of the working group then sends the analytical framework and key questions to the Evidence Review and Synthesis Centre and they begin the review.

The Evidence Review and Synthesis Centre and its clinical experts develop a protocol based on information received from the working group. The protocol contains information about the literature search, the analytic framework, the research questions (key and contextual), and the project schedule. The working group reviews and discusses the protocol and revises it if necessary.

The protocol is also sent to all members of the Task Force for approval and comment. The protocol is then peer reviewed by experts in the topic area. If a partner organization is involved, that organization also reviews the protocol. Comments received from task force members, peer reviewers, and partners (if applicable) are incorporated into the protocol. The final protocol is then approved first by the working group and then by the broader Task Force.

The Evidence Review and Synthesis Centre conducts a systematic review of the available evidence according to the final, approved protocol.

The draft systematic review is peer reviewed and comments are incorporated. The systematic review is finalized once the members of the working group and the Task Force have reviewed and approved the revisions. Subsequently, the chair of the working group and the scientific research manager discuss potential recommendations and clinical considerations arising from the evidence. They then draft the recommendations and share them with the topic working group. Once the topic working group has approved the recommendations, they are then shared with the entire Task Force.

During a meeting of the Task Force, the Evidence Review and Synthesis Centre presents the findings of the systematic review, and the working group presents the draft recommendations. Members of the Task Force discuss the systematic review and recommendations and may propose changes to the wording of the recommendations. The Task Force votes on the draft recommendations. The timeline from approval of the protocol to presentation of the draft recommendations to the Task Force is usually 9 to 15 months.

Following the discussion and voting during a meeting of the Task Force, the chair of the topic working group revises the recommendations and shares the revised version with all members for the Task Force for approval.

The Canadian Task Force on Preventive Health Care Procedure Manual (see the "Availability of Companion Documents" field) provides more details on Task Force methods.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendations

- Strong recommendations are those for which the task force is confident that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation for an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation against an intervention).
- Weak recommendations are those for which the desirable effects probably outweigh the undesirable effects (weak recommendation for an intervention) or undesirable effects probably outweigh the desirable effects (weak recommendation against an intervention) but appreciable uncertainty exists.

Cost Analysis

Economic Implications of Screening

Available data suggest that screening with mammography every two years is associated with costs per quality-adjusted life year that are generally considered to represent good value for money in developed countries. However, many such analyses are based on observational data, which may overestimate the potential benefit of screening compared with trial data. Longer screening intervals will be more economically attractive than shorter screening intervals, assuming that the benefit in terms of reducing breast cancer mortality is retained, as the available evidence suggests.

Method of Guideline Validation

Comparison with Guidelines from Other Groups

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Although members of a task force work group are not necessarily content experts in the clinical area of the guideline, a content expert is part of the evidence review team and the recommendations undergo internal and external peer review by experts in the field and by stakeholders and partners, such as the Canadian Breast Cancer Screening Initiative for these guidelines.

The approved statement of recommendations is sent to external peer reviewers for comment. Comments provided by peer reviewers are shared with the topic working group who decide whether any changes are required. If substantial revisions are required or if the recommendations are controversial, the entire Task Force may be asked to review and discuss the comments. If no substantial revisions are required, the Task Force approves the final recommendations at its next meeting or by email if no meeting is scheduled. If substantial revisions are deemed necessary, the working group makes the changes and brings the recommendations back to the entire Task Force for approval.

Several other organizations have developed recommendations for screening for breast cancer. These are shown in Table 4 in the original guideline document.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate use of screening for breast cancer in average-risk women aged 40-74 years, which may lead to improved health

Potential Harms

Any positive result from screening has emotional costs such as anxiety and worry for patients and their families, and financial costs to both the patient and the health care system as a result of additional and potentially unnecessary diagnostic tests.

Implementation of the Guideline

Description of Implementation Strategy

Considerations for Implementation

Screening with mammography leads to relatively small reductions in mortality, together with increased harm associated with false-positive results and unnecessary interventions. Although the absolute benefit of screening may increase with longer follow-up, it remains relatively small. There was no evidence that screening with mammography reduces all-cause mortality. Although screening might permit surgery for breast cancer at an earlier stage than diagnosis of clinically evident cancer (thus permitting the use of less-invasive procedures for some women), available trial data suggest that the overall risk of mastectomy is significantly increased among recipients of screening compared with women who have not undergone screening.

Although available data suggest that some women would prefer to undergo screening despite its potential harms, many would not. These data show that determining the preferences of individual women about the relative importance of potential benefits and harms is critical in determining who should undergo screening. Sources of information for women should accurately portray the value of mammography and the potential for harm rather than simply provide encouragement. For example, the Public Health Agency of Canada has created a leaflet to assist women with deciding whether or not to undergo screening. In addition, one-page information sheets are available for both clinicians and patients to help with shared decision-making (see Appendix 3 of the original guideline document; additional knowledge translation tools are available at http://canadiantaskforce.ca/patient-resources.html and at http://canadiantaskforce.ca/GRADE.html).

Introducing organized screening programs appears to increase the proportion of women who undergo mammography; such programs should be structured to encourage women to make an informed decision about whether to participate. In some provinces, women may self-refer to organized screening programs; Task Force recommendations are relevant to physicians advising their patients about the potential merits of mammography within or outside of such programs. Reminders linked to an electronic medical record might be helpful for increasing the proportion of women with whom the risks and benefits of mammography are discussed, but this would require further study.

Certain ethnic groups may have higher (e.g., Ashkenazi Jews) or lower (East Asians) risk of death from breast cancer, which may alter the absolute benefit of screening. Rates of screening are low among Aboriginal populations, women with low incomes, and recent immigrants; further work is needed to explain these findings and determine their potential impact.

Access to high-quality facilities with the necessary equipment and expertise in mammography is required for screening. Provincial and regional decision-makers should consider whether access is adequate for people in their jurisdictions who reside outside of major centres. Mobile screening units may help to increase access to screening among women who live in rural or remote communities.

Suggested Performance Measures

An ideal performance measure for preventive services would allow clinicians to assess the quality of care that they are delivering to patients, and allow the writers of guidelines to assess whether their recommendations have influenced clinical practice. The objective of these guidelines is to

improve health among women aged 40–74 years, which requires balancing the potential benefits and harms of using mammography to screen for breast cancer. Although uptake rates of screening are often used as performance measures, women aged 50–74 years who are well-informed might reasonably choose not to undergo mammography. Therefore, performance measures based solely on the number or proportion of women in each age group who undergo mammography may not be suitable.

For health care providers, the proportion of women aged 40–74 years with whom the benefits and harms of mammography are discussed is an appropriate measure of performance. The proportion of women aged 50–74 years who undergo screening mammography at least every three years could be used as a proxy for access to screening services. However, the optimal proportion of women who should undergo screening is dependent on preferences and thus may vary between populations. Measures of quality assurance for facilities providing mammography should be required routinely, including the evaluation of the percentage of women screened who are referred for further testing because of abnormal results found with a program screen (i.e., abnormal call rate) and the number of women detected as having invasive cancer during a routine screening episode per 1,000 women screened (i.e., invasive cancer detection rate).

Implementation Tools

Foreign Language Translations

Patient Resources

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Canadian Task Force on Preventive Health Care, Tonelli M, Gorber SC, Joffres M, Dickinson J, Singh H, Lewin G, Birtwhistle R. Recommendations on screening for breast cancer in average-risk women aged 40-74 years. CMAJ. 2011 Nov 22;183(17):1991-2001. [47 references] PubMed

Adaptation

Not applicable: Guideline was not adapted from another source.

Date Released

1994 Jan (revised 2011 Nov)

Guideline Developer(s)

Canadian Task Force on Preventive Health Care - National Government Agency [Non-U.S.]

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Guideline Committee

Canadian Task Force on Preventive Health Care (CTFPHC) Working Group

Composition of Group That Authored the Guideline

Guidelines Working Group: Marcello Tonelli, Sarah Connor Gorber, Michel Joffres, James Dickinson, Harminder Singh, Gabriela Lewin, Richard Birtwhistle

Financial Disclosures/Conflicts of Interest

Competing Interests

Marcello Tonelli, Michel Joffres, James Dickinson, Harminder Singh, Gabriela Lewin, and Richard Birtwhistle have received support for travel to meetings from the Public Health Agency of Canada. Gabriela Lewin is an employee of Kemptville District Hospital. No other competing interests were declared.

The views of the funding bodies have not influenced the content of the guideline; competing interests have been recorded and addressed. The views expressed in this article are those of the authors and do not represent those of the Public Health Agency of Canada.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Canadian Task Force on Preventive Health Care. Canadian Task Force on the Periodic Health Examination. Canadian Guide to Clinical Preventive Health Care. Ottawa (Canada): Health Canada; 1994. Screening for breast cancer. p. 788-95. [31 references]

A complete list of planned reviews, updates and revisions is available under the What's New section at the Canadian Task Force on Preventive Health Care Web site .

Guideline Availability

Electronic copies: Available from the Canadian Task Force on Preventive Health Care Web site .

Print copies: Available from the Canadian Task Force on Preventive Health Care, Clinical Skills Building, 2nd Floor, Department of Family Medicine, University of Western Ontario, London, ON, N6A 5C1.

Availability of Companion Documents

The following are available:

CTFPHC recommendation for screening for breast cancer with mammography. London (Ontario): Canadian Task Force on Preventive Health Care; 2011. 1 p. Electronic copies: Available in Portable Document Format (PDF) from the Canadian Task Force on Preventive Health Care Web site. Also available in French from the Canadian Task Force on Preventive Health Care Web site.

CTFPHC recommendations concerning clinical breast exam and breast self exam. London (Ontario): Canadian Task Force on Preventive Health Care; 2011. 1 p. Electronic copies: Available in PDF from the Canadian Task Force on Preventive Health Care Web site. Also available in French from the Canadian Task Force on Preventive Health Care Web site.

Breast cancer screening. Systematic review. Hamilton (Ontario): McMaster University; 2011 Oct 7. 145 p. Electronic copies: Available in PDF from the Canadian Task Force on Preventive Health Care Web site.

Appendix 1. Detailed methods. London (Ontario): Canadian Task Force on Preventive Health Care; 2011. 2 p. Electronic copies: Available in PDF from the Canadian Medical Association Journal Web site.

Canadian Task Force on Preventive Health Care methods manual. London (Ontario): Canadian Task Force on Preventive Health Care; 2011 Oct. 86 p. Electronic copies: Available in PDF from the Canadian Task Force on Preventive Health Care Web site. Also available in French from the Canadian Task Force on Preventive Health Care Web site.

Canadian breast cancer screening guidelines. Putting prevention into practice. Video. Available from the Canadian Task Force on Preventive Health Care Web site. Also available in French from the Canadian Task Force on Preventive Health Care Web site.

GRADE companion document to Task Force Guidelines. London (Ontario): Canadian Task Force on Preventive Health Care; 2011. 2 p. Electronic copies: Available in PDF from the Canadian Task Force on Preventive Health Care Web site.

Patient Resources

The following are available:

- Breast cancer screening 2011. Patient algorithm. London (Ontario): Canadian Task Force on Preventive Health Care; 2011. 1 p. Electronic copies: Available in Portable Document Format (PDF) from the Canadian Task Force on Preventive Health Care Web site. Also available in French from the Canadian Task Force on Preventive Health Care Web site.
- FAQ for patients. London (Ontario): Canadian Task Force on Preventive Health Care; 2011. 2 p. Electronic copies: Available in PDF from the Canadian Task Force on Preventive Health Care Web site. Also available in French from the Canadian Task Force on Preventive Health Care Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

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